reasonable reimbursement rate. These hospitals shall have their rates calculated according to the following method:

1. Hospitals failing to comply with the above deadlines shall submit their actual costs and/or volume projections and other required information to the Department in a condition suitable for entry into the data base no later than thirty calendar days subsequent to the respective deadlines. No Global Rate shall be calculated for these hospitals. The hospital's Proposed Alternative Rate shall be devoid of any of the automatic management increases that normally will be calculated for other hospitals receiving an Alternate Rate in accordance with Section 11 of these Guidelines. In lieu of these normally allowed management increases, the hospital will be required to document the need for each management increase at the detailed review with the Analyst before such increases may be included in the Administrative Payment Rate. The hospital may appeal the rate so established to the Hearing Officer in accordance with Section 14 (below). The Proposed Alternate Rate will not be calculated for the hospitals having late submissions until after all other hospitals proceeding under normal review process have received their rate.

2. Should the hospital fail to submit its actual costs and/or volume projections, and other required information to the Department in a condition suitable for entry into the data base as stipulated in 1. above, its 1982 latest approved budget (Global Rate, Proposed Alternative Rate, Administrative Payment Rate or Final Administrative Rate) increased by ½ of the 1983 economic factor shall become its Final Administrative Rate for 1983. The hospital will not be entitled to an appeal of this rate. The 1983 Final Approved Rate will be adjusted for the items specified in Section 15.

C. For any hospital proceeding under the normal methodology which has requested an Alternate Rate, a date for the detailed review with the Analyst shall be set within sixty (60) working days of the issuance of the Proposed Alternate Rate. At least ten (10) working days prior to the date so established the hospital must submit written documentation of all items to be discussed. This documentation will specify each item, the costs associated with the item, and the hospital's rationale for the request. Should the hospital fail to submit the documentation in the allotted time or fail to appear on the established date, it shall have forfeited its right to an appeal, and the Proposed Alternate Rate will become the Final Administrative Rate.

At the Analyst Review, the Analyst shall indicate which items are not supported by sufficient documentation. The hospital must furnish the necessary documentation within ten (10) working days for it to be considered. Following receipt of this documentation, the Department shall neither request nor require further documentation and shall issue the Administrative Payment Rate within thirty (30) working days.

Should the hospital pursue an appeal of the Administrative Payment Rate provided for below (Section 14), the hospital may not submit documentation other than that provided to the Analyst unless the

hospital can demonstrate the existence of good cause for failure to provide the documentation to the Analyst within the deadlines set forth above.

Requests for additional costs for management changes must be justified by a full presentation of the dollar value of the cost, the dollar value of the benefits and a complete explanation of any other benefits resulting from the program which cannot be given a dollar value.

In all cases in which an Administrative Payment Rate is issued following the detailed review, the hospital shall have five (5) working days after notification in which to verify the accuracy of the calculation on the rate schedules and to notify the Department of any corrections to be made. After this time the Administrative Payment Rate shall be issued pursuant to Section 6, B., 12.

D. If a hospital fails to submit its 1982 Actual data by April 30, 1983, and is unable to justify the delay or non-submission, its 1983 per diem will be reduced by five percent (5%) effective the first day of each month, until the submission is received by the Department. This reduced rate shall remain in effect until the Actual data has been processed and found suitable for entry into the 1982 Actual data base. Once the data is approved for entry into the data base the reduced per diem rate will be retroactively increased to the latest rate approved by the Department. The hospital is allowed to submit corrections and changes to its 1982 actual data, resulting from the certified actual audit, subsequent to April 30, 1983, but prior to the date established for determination of the 1984 data base.

E. Auditing of Costs

At a mutually agreed upon time, the Department may perform a detailed on-site review of costs and statistics to verify consistent reporting of data and extraordinary variations in data. The hospital may ask the Department to reconsider its findings, and the Director of Health Economics Services will render a decision. This decision may be appealed according to the Administrative appeal process as defined in Section 14 below. Nothing in this Section modifies, in any way, the rights of any third party to conduct its own audit per contract agreement and/or legal requirements.

5. Methodology for Calculating Global Rates

A. A 1983 Global Rate will be developed from the hospital's 1982 Global Budget established pursuant to the 1982 SHARE Guidelines. Acceptance of the 1983 Global Rate shall constitute a waiver of any right of appeal concerning the 1983 rate and no adjustments to any prior year shall affect the 1983 Global Rate.

1. Hospitals eligible for a Global Rate (see Section 4.B. above) will be given an automatic percentage increase to its adjusted approved 1982 Global Budget. The percentage increase will provide for:

a. General economic factors that will be common to all hospitals, plus,

b. An additional factor to provide for the increases in management changes (they will vary by hospital as described in Section 5.A. (6) below).

2. The adjusted approved 1982 Global Budget will be calculated by adjusting the 1982 Global Budget established for the hospitals on December 1, 1981, by the follow factors:

a. A volume adjustment will be calculated on the variances between 1982 budgeted volumes and the 1983 projected volumes using volume variances as detailed in Exhibit 1.

b. The reasonable costs for legally required changes made in 1982 that were or were not included in the approved 1982 Global approved budget.

c. Difference between the 1982 approved and the 1983 reasonable costs for:

- Interest
- Non-department Depreciation and lease
- Malpractice
- Utilities

d. The amounts that were or were not to be incorporated in the 1982 or 1983 Global Rates to provide for special and/or non-recurring situations.

e. Shifts in cost to/from hospitals from/to other providers of health care.

3. The percentage adjustment described in Paragraph 1 will be applied to all expense items except interest, non-departmental depreciation and lease, malpractice, and utilities. Hospitals desiring additional adjustments for interest and depreciation above the amount approved in the 1982 Global Rate should submit a formal request to the Department of Health together with appropriate supporting data by July 31, 1982.

4. Separate adjustments also will be made to annualize the effect of approved Certificate of Need items not already covered in 2.c. above and other legal changes not included in the 1982 Global Rate.

6/17/83 Submission

OFFICIAL

5. The hospital's specific adjustments carried out in accordance with Section 5.A,1.b. above establishes the reasonable increase in costs for management changes in lieu of the management request and approval procedure that existed in previous Rate Review Guidelines.

   a. For hospitals having 1981 actual costs equal to or less than 95.0% of the median in all three Level I clusters (statewide patient care cluster costs per patient day, statewide general services cluster costs per patient day, and category ancillary cluster costs per admission), the non-physician costs will be increased by two percent (2%).

   b. For hospitals having 1981 actual costs equal to or less than the median in all three Level I cluster, the non-physician costs will be increased by one and one-half percent (1½%).

   c. For hospitals having 1981 actual costs equal to or less than 105% of the median in all three Level I clusters. the non-physician costs will be increased by one percent (1%).

   d. For hospitals having 1981 actual costs equal to or less than 110% of the median in all three Level I clusters. the non-physician costs will be increased by one-half percent (½%).

   e. For all other hospitals, the non-physician costs will not be increased.

   f. The physician portion of the hospital's costs will be increased by one-half (½) of the factor applied to the non-physician's portion.

6. The budgets for physician and non-physician costs will be adjusted separately. Individual ceilings will apply, and there will be no netting of costs between these two portions.

6. Methodology for Alternate Rates

A. A hospital may request an Alternate Rate based on the SHARE rate review methodology by notifying the Coordinator, Hospital Rate Setting Unit, Health Economics Services, New Jersey State Department of Health, CN 360, Trenton, New Jersey 08625, by certified mail on or before November 1, 1982. The Department will notify each such hospital of its Proposed Alternate Rate established under the SHARE methodology on or before December 15, 1982. The Alternate Rate will

be developed in accordance with the process described in the paragraph below and can be appealed as provided in this regulation. There is no assurance that the Alternate Rate so developed will be equal to or greater than the Global Rate initially developed. Once the hospital has requested an Alternate Rate, this rate will be established and implemented.

B. A Proposed Alternate Rate will be developed from the following:

1. Tests at the cost center level of the 1981 actual costs for presumptive reasonableness will be done using peer comparisons of 1981 actual data. The 1981 costs that are not accepted as presumptively reasonable will be deducted from the base period costs before performing subsequent review steps.

2. The 1981 Actual costs revised for base period challenges, will be adjusted for volume projections for 1983 admissions and patient days in accordance with Section 9 below.

3. An industry-wide economic factor as described in Section 10 below, will be applied globally to actual expenses, adjusted in accordance with 1 and 2 above.

4. The hospital will be given an automatic adjustment to its 1981 Actual costs, adjusted in accordance with 1 and 3 above, to provide for management increases in accordance with Section 11 below. Should the hospital determine that the allowed increase is insufficient, the hospital will be required to document the need for additional costs. No further adjustment will be allowed until the hospital can justify the need for all of the management increases allowed in the total approved costs. Should the hospital attempt to document the need for additional monies for management increase, and/or seek an increase of its covered inpatient costs, except as described in Section G-16, it is at risk for the monies allowed through the automatic adjustment.

   For example, a hospital may determine it requires an increase of $100,000 in a particular cost center which has only been given an increase of $30,000 through the normal methodology. That same hospital may have been given an automatic global management increase totaling $250,000. No additional costs will be given in the center requiring the $100,000 adjustment until the need for all of the allowed $250,000 has been explained. Should the hospital substantiate the need for only $200,000 of the automatic adjustment, the remaining $50,000 will be deducted from the approved costs.

6/17/83 Submission

Information relating to the documentation of the need for additional monies for management changes must be submitted to the Analyst in accordance with the time frame established for the detailed review (Section 4.C.).

Any request for additional costs related to legal/management changes approved in 1982 Administrative Payment Rate and not included in the amounts for the automatic adjustments described above will be considered by the Analyst. A presumption of reasonableness of these costs will prevail in those instances where all conditions remain equal.

Over-expenditures in 1981 which are incurred by the hospital without the approval of the Department cannot be appealed in 1983. These expenditures were determined to be unreasonable in 1981 and the hospital had the opportunity to appeal these challenges at the detailed Analyst review and the hearing officer appeal. These expenditures may be specifically identified item by item and requested as new management requests at the 1983 analyst review.

5. The 1981 Adjusted Approved amount will be determined by adjusting the most recent 1981 approved amount (Final Administrative Rate, Administrative Payment Rate, or Proposed Administrative Rate) for actual volume variances, relevant certificate of need and other legal changes, and excluding depreciation and lease costs in the Plant cost center, interest, malpractice and utility costs. This Adjusted Approved amount will be compared to the 1981 actual costs less peer comparison challenges and exclusive of depreciation and lease costs in the Plant cost center, malpractice and utility costs. If the actual costs are in excess of the Adjusted Approved amount, the amount of excess is the overspending challenge. The overspending challenge will be increased by the economic factor and deducted from the reasonable costs for 1983. This adjustment will be made separately for the non-physician and physician portions. No trade-offs will be allowed.

6. Separate analysis will be made of the reasonableness of emergency services costs for inclusion in inpatient rates. Clinic and outpatient costs will not be included in the inpatient rates.

7. Physicians' compensation will be evaluated separately as described in Section 12 below, and that portion of a hospital's cost will be subject to a separate cost ceiling.

8. Any planning regulation implementated during 1981, 1982, or 1983 will be accounted for by appropriate adjustments to these rates.

* [redacted] by 6/17/83. NJ letter

10. A hospital may either accept its Proposed Alternate Rate or proceed to a review with the Analyst. Request for additional costs for management changes must be justified by a full presentaton of the dollar value of the benefits and a complete explanation of any other benefits resulting from the program which cannot be given a dollar value. If the hospital accepts the Proposed Alternate Rate, this becomes the Final Administrative Rate.

11. The Department may perform a detailed on-site review of costs and statistics to verify consistent reporting of data and extraordinary variations in data. The hospital may ask the Department to reconsider its findings. The decision will be made by the Director of Health Economics Services and may be appealed according to Section 14 below.

12. A hospital's Administrative Payment Rate (APR) will be issued subsequent to the completion of the review with the Analyst. The review will be undertaken in accordance with procedures established by Health Economics Services. If the hospital accepts the Administrative Payment Rate, this becomes the Final Administrative Payment Rate.

13. A hospital may appeal its Administrative Payment Rate as outlined in Section 14, Appeals.

7. Computational Techniques

A. For the purpose of detailed analysis of hospital costs, cost centers are separated into four levels:

1. Level I cost centers are those that can be grouped for aggregate tests of reasonableness. These are cost centers for which a good deal of commonality exists among similar hospitals and for which reasonable units of service can be defined.

2. Level 2 cost centers are those for which commonality exists among similar hospitals and units of service are available.

3. Level 3 cost centers include those that are not readily comparable among similar hospitals. These cost centers will be reviewed only for the reasonableness of proposed cost increases.

4. Level 4 cost centers are those that have no bearing on determination of inpatient payment rates.

Exhibit I, "Cost Center Record" shows cost centers and their analysis level.

B. In order to eliminate the effects of geographic compensation differentials among hospitals in various areas, compensation costs will be equalized in analyzing and comparing cost centers costs.

1. Compensation equalizing will be done separately utilizing the

ten (10) labor market areas. (See Exhibit II).

2. Each hospital's actual total employee compensation will be equalized by multiplying total employee compensation by an index that is the ratio of the state-wide to the area-wide median rates. Total employee compensation includes salaries and fringe benefits. Included in fringe benefits is the value of free and subsidized meals and the imputed value of self-insurance.

3. The total equalized costs of each cost center are calculated by adding supplies, services, other expenses, depreciation and leases to equalized total compensation and subtracting expense recoveries. This total is then divided by the unit of service specified in Exhibit I to calculate unit costs for Level I and II cost centers. These unit costs are used to quantify present cost levels that will be questioned as presumptively unreasonable.

   Unit costs for each cost center in each hospital are calculated and analyzed within appropriate peer groupings specified in Exhibit I.

   For each cost center in a hospital, the amount to be challenged will be all costs above the reasonableness limit established in Exhibit I. In order to explain a challenged amount, the hospital must explain total costs within the cost center.

   The amounts disallowed are converted from a compensation equalized basis to the hospital's reported basis so that the amounts disallowed for a particular hospital are consistent with the actual dollars reported on the SHARE Actual Forms.

8. Reasonableness Test-Peer Comparisons

   A. If the equalized actual costs of Level I General Services cost centers are less than 110 percent the state-wide median costs per patient day, then this segment of the actual costs will be presumed reasonable.

   B. If the equalized actual cost of Level I Ancillary Services cost centers are less than 110 percent the category median cost per admission, then this segment of the projected costs will be presumed reasonable.

   C. If the equalized actual costs of the Level I Inpatient Care cost centers are less than 110 percent the state-wide median costs per patient day, then this segment of the actual costs will be presumed reasonable.

   D. If the equalized Level I unit costs of any of the above clusters exceeds the reasonableness screen, then the costs in excess of that screen shall be considered presumptively unreasonable. Peer comparisons shall be made at the cost center level in order to provide detailed support for the amounts challenged in the cluster. These category and reasonableness limits are specified in Exhibit I, "Cost Center Record". The costs reviewed are covered inpatient costs as given by SHARE Form F, 1981 actual.

   E. Level II cost centers and physician costs (including fringe benefits but

not equalized) will be analyzed separately. They will not be included in the cluster totals nor in the analysis by cost center of cluster challenges. The challenge ratio will be that specified on Exhibit I for each cost center.

F. Base Period Challenges will be deducted from the actual base before making subsequent review steps.

9. Volume Changes

Reasonable changes in expenses resulting from volume changes will be determined by calculating for each cost center in each hospital, the portion of the budgeted change that is accounted for by changes in volume, using the volume variability factors specified in Exhibit I, and the following units of service.

A. Inpatient admissions will be used for the following cost centers:

Anesthesia	Operating and Recovery Rooms
Blood Bank	Other Physical Medicine
Cardiac Catherization	Pharmacy
Central Sterile Supply	Physical Therapy
Delivery and Labor	Radiology
Dialysis	Respiratory Therapy
Electrodiagnosis	Therapeutic Radiology
Laboratory	Fiscal
Nuclear Medicine	Medical Records

Admissions from the emergency room will be used for the inpatient portion of the emergency room cost center.

B. Patient days will be used for all other cost centers.

C. In making these calculations physicians fees will be considered variable and physician salaries fixed.

D. The base of making these calculations for the proposed Alternative Rate will be 1981 actual costs less any base period challenges. The volume change will be calculated on the basis of the increase/decrease of 1983 projected patient days or admissions compared to 1981 actuals.

10. Reasonableness Tests-Increases Due to Economic Factors

A. The Commissioner will develop and promulgate an industry-wide economic factor to account for presumptively reasonable increases in expenses due to inflation. compensation increases, and other factors increasing costs.

B. In establishing reimbursement rates, the Commissioner subscribes to the view that determination of compensation rates is a management prerogative. Accordingly, the Commissioner is taking the position that compensation increases in excess of the economic factor should be made only through improved utilization of personnel, upgrading of the quality of employees, increases in productivity, and other cost contain ment efforts.

C. This economic factor will be applied globally to total covered inpatient costs exclusive of:

1. Mortgage, and other facility interest charged to the Plant cost center.

2. Depreciation and lease costs for building, major moveable and other miscellaneous equipment reported in the Plant cost center.

3. Base period challenges.

4. Malpractice Insurance and Utility Costs.

D. Interest rates will be screened against the prevailing interest rate available through refinancing of debt and the cost of refinancing.

11. Management Increases

Increases in the intensity of a particular service or for other programatic changes deemed necessary by the management of the hospital will be allowed automatically in accordance with the formula outlined below. The amount to be allowed will be determined using a cost center by cost center analysis; however, the management of the hospital should use its own discretion in determining how to allocate these monies to the various departments of the hospital in order to best meet the needs of the patients.

For each hospital a comparison shall be made of the unit cost of each Level I and Level II cost center to the median cost and adjustments will be made to increase the base year costs as follows:

Hospital's Unit Cost is:	Allowance
equal to or greater than the median	0
equal to or greater than 95% of the median, but less than the median	1
equal to or greater than 90% of the median, but less than 95% of the median	2
equal to or greater than 80% of the median, but less than 90% of the median	3
less than 80% of the median	4

This adjustment shall be made separately for physician and non-physician sectors, and the management of the hospital should not trade-off the allowed costs between these two sectors.

These allowances may be appealed in accordance with Section 6.B, Item 4, above. Should the hospital pursue such an appeal, it will be at risk for the adjustments made in accordance with the formula given above.